

1916

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air, Md.				c. LENGTH OF STAY IN 1b 3YRS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD COUNTY HOME				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JOHN J. BARRETT				4. DATE OF DEATH Month Day Year FEB. 26 1959			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 23, 1982		9. AGE (In years last birthday) yrs. 77		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRACTICAL MALE NURSE			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND Wisconsin		12. CITIZEN OF WHAT COUNTRY? UNITED STATES
13. FATHER'S NAME RICHARD BARRETT				14. MOTHER'S MAIDEN NAME MARY CONLEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 221-10-9419		17. INFORMANT Address Mrs. HELEN B. Mattingly P.O. 126, Leonardtown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chr. Hypertensive Cardio-vascular disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Sudden 10 yrs?							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec. 1955 , to Feb. 26 1959 , that I last saw the deceased alive on Feb. 24 1959 , and that death occurred at 9:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Willard P. Hudson Forest Hill, Md. Feb. 26, 1959							
ACTUAL SIGNATURE Willard P. Hudson							
PHYSICIAN'S NAME (Type) WILLARD P. HUDSON M.D. FOREST HILL, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/28/59		22c. NAME OF CEMETERY OR CREMATORY Our Lady's		22d. LOCATION (City, town, or county) (State) Medley's Neck, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.				24a. REC'D BY REGISTRAR DATE MAR 3 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **1** hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72** hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1917

CERTIFICATE OF DEATH

01920

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARTFORD</u>		MARYLAND		STATE <u>Feb 11/59</u> COUNTY <u>HARTFORD</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bel Air</u>		LENGTH OF STAY (in this place) <u>35 YEARS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bel Air Md</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>Box 1 St</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Walter E Bennington</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Feb 11 1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED Nov 11 - 1898</u>	8. DATE OF BIRTH <u>Nov 11 - 1898</u>	9. AGE last birthday <u>60</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Policeman</u>		11. BIRTHPLACE (State or foreign country) <u>Whitford Hartford Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Frederick Bennington</u>				14. MOTHER'S MAIDEN NAME <u>Elorence Targert</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u>		16. SOCIAL SECURITY NO. <u>215-22-8065</u>		17. INFORMANT & ADDRESS <u>Mrs Florence Bennington Bel Air Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
443X IMMEDIATE CAUSE (A) <u>CARDIAC ARREST</u>						<u>IMMEDIATE</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>						<u>10 YRS</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>MAR</u> , 19 <u>47</u> , to <u>FEB</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9 FEB</u> , 19 <u>59</u> , and that death occurred at <u>4:15 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>J.P. Adwell</u>		M.D. <u>401 Franklin St Bel Air Md</u>		DATE SIGNED <u>11 Feb 59</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>Feb 13/59</u>		NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		LOCATION (City, town, or county) (State) <u>Bel Air Hartford Md</u>	
24. REC'D BY REGISTRAR DATE <u>FEB 13 '59</u>		REGISTRAR'S SIGNATURE <u>Arthur L. Kneass</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph T. Foster</u>		ADDRESS <u>Bel Air Md</u>	

1931

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltan</u>		c. LENGTH OF STAY IN lb <u>6 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RD 2</u>		e. STREET ADDRESS <u>RD 1</u>	
3. NAME OF DECEASED (Type or print) <u>Ray Van Lear Bowser JR</u>		4. DATE OF DEATH <u>February 28</u> 19 <u>59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 4, 1938</u>
9. AGE (In years last birthday) <u>20</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pipe Fitter Helper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shipyard</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Ray Van Lear Bowser SR</u>		14. MOTHER'S MAIDEN NAME <u>Marie Mulligan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give year or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u>220-34-5906</u>	
17. INFORMANT <u>Roy Van Lear Bowser</u> Address <u>Box 219 RD 1 Stockton Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull</u> <u>816 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c), stating the underlying cause lost. (c) <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident auto - auto accident</u>	
20c. TIME OF INJURY Month, Day, Year <u>11:30 a.m. 2-28 1959</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>RD 2</u>		20f. (City or town) <u>Beltan Harford Md.</u> (County) <u> </u> (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Baltimore Md</u> DATE SIGNED <u>3-1-59</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAR 4/1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BELAIR MEMORIAL GARDENS</u>		22d. LOCATION (City, town, or county) <u>BELAIR MD</u> (State) <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Foster, Bel Air, Md.</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>MAR 4 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>			

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1931

[Faint, mostly illegible text and markings on the form, including what appears to be a signature and various checkboxes.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1918

CERTIFICATE OF DEATH

Reg. Dist. No.

01922

1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVERDALE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HOWARD</u> <u>Woodrow</u> <u>Bull</u>				4. DATE OF DEATH Month Day Year <u>FEBRUARY</u> <u>25</u> <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 8, 1913</u>	
9. AGE (In years last birthday) <u>45</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Milton J. Bull SR -</u>				14. MOTHER'S MAIDEN NAME <u>Arrvie Elliott</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-10-8887</u>		17. INFORMANT <u>Mr. Sewell Bull</u> Address <u>44 East Gordon St. Bel Air, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>24 hr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>2-24-59</u> , 19 <u>59</u> , to <u>FEBRUARY 25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2-24-59</u> , 19 <u>59</u> , and that death occurred at <u>9:30 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Low St. Aberdeen, Md.</u> DATE SIGNED <u>2-26-59</u>							
ACTUAL SIGNATURE <u>Peter P. Rodman</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Peter P. Rodman</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 27, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BEL AIR MEMORIAL GARDENS</u>		22d. LOCATION (City, town, or county) (State) <u>BEL AIR, Harford Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u> ADDRESS <u>W. Broadway & W. 11th Sts. Bel Air, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. K...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

71

M

01923

1919

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)
First Middle Last
4. DATE OF DEATH
Month Day Year
5. SEX
6. COLOR OR RACE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH
9. AGE (In years last birthday)
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME
14. MOTHER'S MAIDEN NAME
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m.
20d. INJURY OCCURRED
While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 1959 to 2-25 1959, that I last saw the deceased alive on 2-25-59, and that death occurred at 10:45 PM from the causes and on the date stated above.
ADDRESS (Street, city or town, state)
DATE SIGNED
ACTUAL SIGNATURE
PHYSICIAN'S NAME (Type)
22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF
22c. NAME OF CEMETERY OR CREMATORY
22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
24a. REC'D BY REGISTRAR DATE
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MED

FOR STATE
HEALTH DEPT.

MEDICAL CERTIFICATION

VS. A15ME
5M 2/57



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
ISM 9/55

BALTIMORE, 18

01925

1920

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harro-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>31 Aberdeen</u>	
c. LENGTH OF STAY IN 1b <u>47 days</u>		d. STREET ADDRESS <u>'Paradise Rd.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth Hollis Coale</u>		4. DATE OF DEATH Month <u>2</u> Day <u>4</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 8th - 1888</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-wife</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Hannah Smith</u>		14. MOTHER'S MAIDEN NAME <u>Mary Hendon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Clyde Foote</u>		Address <u>Aberdeen, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the stomach</u> <u>199.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic heart disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>1953</u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1953</u> , 19 <u>53</u> , to <u>2-4-59</u> , that I last saw the deceased alive on <u>2-4-59</u> , and that death occurred at <u>4-20-59</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Peter P. Rodman</u> M.D.		ADDRESS (Street, city or town, state) <u>8 Law Street</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Peter P. Rodman</u>		<u>Aberdeen, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/7/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Episcopal Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Churchville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Garvey</u>		24a. REC'D BY REGISTRAR <u>FEB 10 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hume</u>

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 1939 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01926

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u> c. LENGTH OF STAY IN It <u>instant</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RD 2</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u> d. STREET ADDRESS <u>RD 2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Gene Winfield Cullum</u> First Middle Last 4. DATE OF DEATH <u>February 28 19 59</u> Month Day Year		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>May 14, 1939</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>19</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Inspector</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>National Guard</u> 11. BIRTHPLACE (State or foreign country) <u>Harford Co., Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.,</u>		13. FATHER'S NAME <u>Roland R. Cullum</u> 14. MOTHER'S MAIDEN NAME <u>Elsie Mitchell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-36-9373</u> 17. INFORMANT <u>Roland R. Cullum, Bel Air, R.D., Maryland</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull</u> <u>816x</u> DUE TO <u>Compound, comminuted fracture</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>both bones both legs</u> (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident, auto - auto type</u>	
20c. TIME OF INJURY Month, Day, Year <u>11:58 a.m. 2-28 19 59</u> Hour a.m. p.m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>RD 2</u> 20f. (City or town) <u>Bel Air</u> (County) <u>Harford</u> (State) <u>md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, md</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>3-1-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>Mar. 4, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u> 22d. LOCATION (City, town, or county) (State) <u>Calvary, Harford, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward R. Komer Jr</u> ADDRESS <u>Abingdon, Md.,</u>		24a. REC'D BY REGISTRAR <u>MAR 4 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Komer</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director for filing. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Instant

Track Inspector National Guard Roland R. Cullum
Harford Co., Maryland
U.S.A.
Roland R. Cullum, 801 Ave. F.D., Maryland
17-30-2373

Calvary, Maryland
Calvary
Bristol, Mo.
Calvary, Maryland
Calvary, Maryland
Calvary, Maryland

1921 **CERTIFICATE OF DEATH**

Reg. Dist. No. 01927

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Harford</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Harford</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BEL AIR</u>	LENGTH OF STAY (in this place) <u>30</u>	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BEL AIR</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Fulford Ave.</u>		STREET ADDRESS (If rural give location) <u>Fulford Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>Nicholas J. DEMAS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 17, 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>JUNE 5, 1892</u>
		9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Restaurant Proprietor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>	11. BIRTHPLACE (State or foreign country) <u>Trikkala, Greece</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>JAMES DEMAS</u>		14. MOTHER'S MAIDEN NAME <u>HELEN DEMAS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-34-4565</u>	
		17. INFORMANT & ADDRESS <u>Mrs. Mary Charas DEMAS 102 Fulford Ave. Bel Air, Md.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			18. MEDICAL CERTIFICATION
420.1 IMMEDIATE CAUSE (A) <u>Myocardial Infarction</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hour</u>
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary thrombosis</u>			<u>several hours</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>ARTERIOSCLEROTIC and hypertensive cardiovascular disease</u>			<u>10 years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Intermittent congestive heart failure</u>			<u>5 years</u>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Aug. 13</u> , 19 <u>54</u> , to <u>FEB. 17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>FEB. 17</u> , 19 <u>59</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Paul J. Stangor Jr.</u>		ADDRESS (Street, city, town, state) <u>M.D. 115 FULFORD AVE. BEL AIR, MD.</u>	
		DATE SIGNED <u>2/18/59</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>2/20/1959</u>	NAME OF CEMETERY OR CREMATORY <u>BEL AIR MEMORIAL GARDENS</u>	LOCATION (City, town, or county) (State) <u>BEL AIR, Harford Co., Maryland</u>
24. REC'D BY REGISTRAR DATE <u>FEB 20 '59</u>	REGISTRAR'S SIGNATURE <u>C. B. & K. H. H.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u> ADDRESS <u>W. Broadway + Williams St. BEL AIR, Maryland</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

1921

Page No. 21

NAME OF DECEASED

AGE

SEX

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Time of Death

Occupation

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Minister

Signature of Undertaker

Signature of Burial Officer

Signature of Cemetery

Signature of Funeral Home

Signature of Mortuary

Signature of Embalmer

Signature of Preparator

Signature of Restorer

Signature of Artist

Signature of Sculptor

Signature of Painter

Signature of Designer

Signature of Architect

Signature of Engineer

Signature of Surveyor

Signature of Draftsman

Signature of Mechanic

Signature of Electrician

Signature of Plumber

Signature of Carpenter

Signature of Joiner

Signature of Cabinetmaker

Signature of Upholsterer

Signature of Tailor

Signature of Dressmaker

Signature of Hatter

Signature of Shoemaker

Signature of Saddler

Signature of Leatherworker

Signature of Jeweler

Signature of Watchmaker

Signature of Optician

Signature of Photographer

Signature of Printer

Signature of Bookbinder

Signature of Stationer

Signature of Stationery Writer

Signature of Letter Writer

Signature of Copy Writer

Signature of Advertiser

Signature of Publicist

Signature of Journalist

Signature of Editor

Signature of Publisher

Signature of Printer

Signature of Bookbinder

Signature of Stationer

Signature of Stationery Writer

Signature of Advertiser

Signature of Publicist

Signature of Journalist

Signature of Editor

Signature of Publisher

Signature of Printer

Signature of Bookbinder

Signature of Stationer

Signature of Stationery Writer

Signature of Advertiser

Signature of Publicist

Signature of Journalist

Signature of Editor

Signature of Publisher

Signature of Printer

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Signature of Stationer

Signature of Stationery Writer

Signature of Advertiser

Signature of Publicist

Signature of Journalist

Signature of Editor

Signature of Publisher

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Signature of Stationery Writer

Signature of Advertiser

Signature of Publicist

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Signature of Publicist

Signature of Journalist

Signature of Editor

Signature of Publisher

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Signature of Stationer

Signature of Stationery Writer

Signature of Advertiser

Signature of Publicist

Signature of Journalist

Signature of Editor

Signature of Publisher

Signature of Printer

Signature of Bookbinder

Signature of Stationer

Signature of Stationery Writer

Signature of Advertiser

Signature of Publicist

Signature of Journalist

Signature of Editor

Signature of Publisher

Signature of Printer

Signature of Bookbinder

Signature of Stationer

Signature of Stationery Writer

Signature of Advertiser

Signature of Publicist

Signature of Journalist

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 1934 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01928

Item 7 Film 6239 3-13-59 et

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penn</u> b. COUNTY <u>Phila</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Conowingo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>75 X-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hopkins Cove, Sansquehanna River</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Viggo</u> First <u>Hansen</u> Middle <u>Hansen</u> Last <u>Hansen</u>		4. DATE OF DEATH <u>February</u> Month <u>27</u> Day <u>1959</u> Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 19 1889</u> 69 yrs.
9. AGE (In years last birthday) <u>69</u>		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Engineer Phila Electric Co</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shell</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Hansen</u>		14. MOTHER'S MAIDEN NAME <u>Maria Christenson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>10-10-10</u>	
17. INFORMANT <u>James Hansen</u> Address <u>Upper Warty Phila Pa</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Decerebration</u> 863X DUE TO <u>Third degree burns entire body</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>body</u> (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Helicopter hit power wire & crashed</u>	
20c. TIME OF INJURY Month, Day, Year <u>2-27-59</u> Hour <u>6</u> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Sansquehanna River</u>		20f. (City or town) <u>Conowingo</u> (County) <u>Harford</u> (State) <u>MD.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> Bel Air <u>MD</u> DATE SIGNED <u>2-27-59</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Feb 28, 1959</u>		22b. DATE THEREOF <u>Mar 5 '59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Marshallville</u>		22d. LOCATION (City, town, or county) <u>Out of Phila Penna</u> (State) <u>Penna</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H S Bailey</u> ADDRESS <u>Wilmington</u>		24a. REC'D BY REGISTRAR <u>Arthur S. House</u> 24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1935 CERTIFICATE OF DEATH

01929

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jarrettsville				c. LENGTH OF STAY IN lb 1 mon.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				/d. STREET ADDRESS X Street			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last ANNIE MARY HASLETT.				4. DATE OF DEATH Month Day Year Feb. 17 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 29, 1884	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Shane, Balto. Co. Md.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME William Simms				14. MOTHER'S MAIDEN NAME Mc Clair			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 0-----		17. INFORMANT Lewie W. Haslett Address Street, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Cardio-vascular Heart Disease DUE TO (b) Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INTERVAL BETWEEN ONSET AND DEATH years -							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Sept , 19 58 , to 17 Feb , 19 59 , that I last saw the deceased alive on 17 Feb , 19 59 , and that death occurred at 1 p. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Jarrettsville, Md. DATE SIGNED Feb 24 '59							
ACTUAL SIGNATURE Thos. G. S. Morley Jr. M.D. Jarrettsville, Md.							
PHYSICIAN'S NAME (Type) Thos. G. S. Morley Jr.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/19/1959		22c. NAME OF CEMETERY OR CREMATORY William Watters		22d. LOCATION (City, town, or county) (State) Cooptown Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Futz ADDRESS Jarrettsville, Md.				24a. REC'D BY REGISTRAR FEB 24 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1911

Name of Deceased		Age		Sex		Race		Religion		Marital Status		Occupation		Cause of Death		Date of Death		Place of Death		Signature of Registrar		Signature of Medical Officer	

1922 CERTIFICATE OF DEATH

01930

Reg. Dist. No.

INSTRUCTIONS

1. hours after death.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. After this the bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ABC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u> COUNTY <u>Harford</u>			
CITY OR TOWN <u>Havre de Grace</u>		LENGTH OF STAY (in this place) <u>20 Min.</u>		CITY OR TOWN <u>Forest Hill</u>		Rural	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>DORA ALBERTA HORN</u>				<u>February 2, 1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 9, 1898</u>	9. AGE last birthday <u>60</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Samuel Robb</u>				14. MOTHER'S MAIDEN NAME <u>Emma Coler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT & ADDRESS <u>Mrs. Harvey Keys Forest Hill Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE (A) <u>Pulmonary Edema, acute</u>						2 or 3 hours	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Congestive Heart failure</u>						1 year	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Arteriosclerotic cardiovascular disease</u>						10 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes mellitus</u>						2 years	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 15, 1957</u> , to <u>Feb. 1, 1959</u> , that I last saw the deceased alive on <u>Feb. 1, 1959</u> , and that death occurred at <u>6:50 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Paul S. Stonestifer, Jr.</u>				ADDRESS (Street, city, town, state) <u>115 Fulford Ave., Bel Air, Md.</u>		DATE SIGNED <u>2/2/59</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/4/1959</u>		NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Garden</u>		LOCATION (City, town, or county) (State) <u>Bel Air Md.</u>	
24. REC'D BY REGISTRAR <u>FEB 4 '59</u>		REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Hunt</u>		ADDRESS <u>Garrettsville Md.</u>	

CERTIFICATE OF DEATH

Form No. 1

1. NAME OF DECEASED (Print or Write)

2. SEX (Male or Female)

3. AGE (Years, Months, Days)

4. PLACE OF BIRTH (Country, State, County, City, Town, or Village)

5. MARRIAGE (Married, Single, Widowed, Divorced)

6. OCCUPATION

7. CAUSE OF DEATH (Print or Write)

8. PLACE OF DEATH (Print or Write)

9. DATE OF DEATH (Month, Day, Year)

10. SIGNATURE OF PHYSICIAN (Print or Write)

11. SIGNATURE OF REGISTRAR (Print or Write)

12. SIGNATURE OF WITNESSES (Print or Write)

13. SIGNATURE OF DECEASED (Print or Write)

14. SIGNATURE OF NEXT OF KIN (Print or Write)

15. SIGNATURE OF CLERK (Print or Write)

16. SIGNATURE OF JUDGE (Print or Write)

17. SIGNATURE OF SHERIFF (Print or Write)

18. SIGNATURE OF CONSTABLE (Print or Write)

19. SIGNATURE OF TOWNSHIP CLERK (Print or Write)

20. SIGNATURE OF COUNTY CLERK (Print or Write)

21. SIGNATURE OF STATE CLERK (Print or Write)

22. SIGNATURE OF U.S. MARSHAL (Print or Write)

23. SIGNATURE OF U.S. DISTRICT JUDGE (Print or Write)

24. SIGNATURE OF U.S. ATTORNEY (Print or Write)

25. SIGNATURE OF U.S. SENATOR (Print or Write)

26. SIGNATURE OF U.S. REPRESENTATIVE (Print or Write)

27. SIGNATURE OF U.S. SENATOR-ELECT (Print or Write)

28. SIGNATURE OF U.S. REPRESENTATIVE-ELECT (Print or Write)

29. SIGNATURE OF U.S. SENATOR-AT-LARGE (Print or Write)

30. SIGNATURE OF U.S. REPRESENTATIVE-AT-LARGE (Print or Write)

31. SIGNATURE OF U.S. SENATOR-AT-LARGE-ELECT (Print or Write)

32. SIGNATURE OF U.S. REPRESENTATIVE-AT-LARGE-ELECT (Print or Write)

33. SIGNATURE OF U.S. SENATOR-AT-LARGE-ELECT-ELECT (Print or Write)

34. SIGNATURE OF U.S. REPRESENTATIVE-AT-LARGE-ELECT-ELECT (Print or Write)

35. SIGNATURE OF U.S. SENATOR-AT-LARGE-ELECT-ELECT-ELECT (Print or Write)

36. SIGNATURE OF U.S. REPRESENTATIVE-AT-LARGE-ELECT-ELECT-ELECT (Print or Write)

37. SIGNATURE OF U.S. SENATOR-AT-LARGE-ELECT-ELECT-ELECT-ELECT (Print or Write)

38. SIGNATURE OF U.S. REPRESENTATIVE-AT-LARGE-ELECT-ELECT-ELECT-ELECT (Print or Write)

RECEIVED

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT THIS CERTIFICATE IS CORRECTLY FILLED OUT AND THAT THE SIGNATURES ARE PROPERLY OBTAINED. THE REGISTRAR IS NOT RESPONSIBLE FOR THE CONTENTS OF THIS CERTIFICATE.

CERTIFICATE OF DEATH

Reg. Dist. No.

01931

1936

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Aberdeen (Rural)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R.D. #1, Box 364</u>				d. STREET ADDRESS <u>R.D. #1, Box 364</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Franklin O. Johnson</u>				4. DATE OF DEATH Month Day Year <u>February 18 1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Sept 24, 1916</u>	9. AGE (In years lost birthday) <u>42</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Oscar M. Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Alice Palmer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-07-4878</u>		17. INFORMANT Address <u>441 W. Bel Air</u> <u>Ruth Greenland, Aberdeen, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma R</u> <u>162.1</u> DUE TO <u>lung.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>6-15</u> , 19 <u>58</u> , to <u>2-18</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2-18</u> , 19 <u>59</u> , and that death occurred at <u>9 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D. <u>Bel Air, Md.</u>				ADDRESS (Street, city or town, state) <u>2-18-59</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Gerald C Palmer M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/21/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Spesutia Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Perryman, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Tarring</u>				ADDRESS <u>Tarring Funeral Home</u> <u>Aberdeen, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kinn</u>	
				DATE <u>FEB 24 '59</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED J. L. Fox		2. SEX Male		3. AGE 65		4. DATE OF DEATH Jan 1, 1914		5. PLACE OF DEATH Home	
6. OCCUPATION None		7. CAUSE OF DEATH Heart		8. MANNER OF DEATH Natural		9. PLACE OF BIRTH Maryland		10. DATE OF BIRTH Jan 1, 1849	
11. SIGNATURE OF DECEASED		12. SIGNATURE OF WITNESSES		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF CLERK		15. SIGNATURE OF REGISTRAR	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF WITNESSES		18. SIGNATURE OF PHYSICIAN		19. SIGNATURE OF CLERK		20. SIGNATURE OF REGISTRAR	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF WITNESSES		23. SIGNATURE OF PHYSICIAN		24. SIGNATURE OF CLERK		25. SIGNATURE OF REGISTRAR	
26. SIGNATURE OF DECEASED		27. SIGNATURE OF WITNESSES		28. SIGNATURE OF PHYSICIAN		29. SIGNATURE OF CLERK		30. SIGNATURE OF REGISTRAR	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF WITNESSES		33. SIGNATURE OF PHYSICIAN		34. SIGNATURE OF CLERK		35. SIGNATURE OF REGISTRAR	
36. SIGNATURE OF DECEASED		37. SIGNATURE OF WITNESSES		38. SIGNATURE OF PHYSICIAN		39. SIGNATURE OF CLERK		40. SIGNATURE OF REGISTRAR	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF WITNESSES		43. SIGNATURE OF PHYSICIAN		44. SIGNATURE OF CLERK		45. SIGNATURE OF REGISTRAR	
46. SIGNATURE OF DECEASED		47. SIGNATURE OF WITNESSES		48. SIGNATURE OF PHYSICIAN		49. SIGNATURE OF CLERK		50. SIGNATURE OF REGISTRAR	
51. SIGNATURE OF DECEASED		52. SIGNATURE OF WITNESSES		53. SIGNATURE OF PHYSICIAN		54. SIGNATURE OF CLERK		55. SIGNATURE OF REGISTRAR	
56. SIGNATURE OF DECEASED		57. SIGNATURE OF WITNESSES		58. SIGNATURE OF PHYSICIAN		59. SIGNATURE OF CLERK		60. SIGNATURE OF REGISTRAR	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF WITNESSES		63. SIGNATURE OF PHYSICIAN		64. SIGNATURE OF CLERK		65. SIGNATURE OF REGISTRAR	
66. SIGNATURE OF DECEASED		67. SIGNATURE OF WITNESSES		68. SIGNATURE OF PHYSICIAN		69. SIGNATURE OF CLERK		70. SIGNATURE OF REGISTRAR	
71. SIGNATURE OF DECEASED		72. SIGNATURE OF WITNESSES		73. SIGNATURE OF PHYSICIAN		74. SIGNATURE OF CLERK		75. SIGNATURE OF REGISTRAR	
76. SIGNATURE OF DECEASED		77. SIGNATURE OF WITNESSES		78. SIGNATURE OF PHYSICIAN		79. SIGNATURE OF CLERK		80. SIGNATURE OF REGISTRAR	
81. SIGNATURE OF DECEASED		82. SIGNATURE OF WITNESSES		83. SIGNATURE OF PHYSICIAN		84. SIGNATURE OF CLERK		85. SIGNATURE OF REGISTRAR	
86. SIGNATURE OF DECEASED		87. SIGNATURE OF WITNESSES		88. SIGNATURE OF PHYSICIAN		89. SIGNATURE OF CLERK		90. SIGNATURE OF REGISTRAR	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF WITNESSES		93. SIGNATURE OF PHYSICIAN		94. SIGNATURE OF CLERK		95. SIGNATURE OF REGISTRAR	
96. SIGNATURE OF DECEASED		97. SIGNATURE OF WITNESSES		98. SIGNATURE OF PHYSICIAN		99. SIGNATURE OF CLERK		100. SIGNATURE OF REGISTRAR	

TO BE FILLED BY THE REGISTRAR OF DEATHS

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

5. PLACE OF DEATH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. PLACE OF BIRTH

10. DATE OF BIRTH

11. SIGNATURE OF DECEASED

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF PHYSICIAN

14. SIGNATURE OF CLERK

15. SIGNATURE OF REGISTRAR

16. SIGNATURE OF DECEASED

17. SIGNATURE OF WITNESSES

18. SIGNATURE OF PHYSICIAN

19. SIGNATURE OF CLERK

20. SIGNATURE OF REGISTRAR

21. SIGNATURE OF DECEASED

22. SIGNATURE OF WITNESSES

23. SIGNATURE OF PHYSICIAN

24. SIGNATURE OF CLERK

25. SIGNATURE OF REGISTRAR

26. SIGNATURE OF DECEASED

27. SIGNATURE OF WITNESSES

28. SIGNATURE OF PHYSICIAN

29. SIGNATURE OF CLERK

30. SIGNATURE OF REGISTRAR

31. SIGNATURE OF DECEASED

32. SIGNATURE OF WITNESSES

33. SIGNATURE OF PHYSICIAN

34. SIGNATURE OF CLERK

35. SIGNATURE OF REGISTRAR

36. SIGNATURE OF DECEASED

37. SIGNATURE OF WITNESSES

38. SIGNATURE OF PHYSICIAN

39. SIGNATURE OF CLERK

40. SIGNATURE OF REGISTRAR

41. SIGNATURE OF DECEASED

42. SIGNATURE OF WITNESSES

43. SIGNATURE OF PHYSICIAN

44. SIGNATURE OF CLERK

45. SIGNATURE OF REGISTRAR

46. SIGNATURE OF DECEASED

47. SIGNATURE OF WITNESSES

48. SIGNATURE OF PHYSICIAN

49. SIGNATURE OF CLERK

50. SIGNATURE OF REGISTRAR

46

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01932

1937

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Mary Middle Regina Last Johnson		4. DATE OF DEATH Month Feb. Day 1 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 13, 1900
9. AGE (In years last birthday) 58 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laboratory Tech.,	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laboratory Tech.,		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.,	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.,	
13. FATHER'S NAME Harry G. Smith		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-22-0997	
17. INFORMANT Boyd N. Johnson,		Address Edgewood, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of Cervix 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Melanosis thru out Abdomen (c) Hemorrhage, Indamy to Carcinoma		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. 11 Month 19 Day 1 Year 1959 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/28 , 19 58 , to 2/1 , 19 59 , that I last saw the deceased alive on 2/1 , 19 59 , and that death occurred at 10:55 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE E. Louis Kahan		M.D. Box 966 Edgewood Md	
PHYSICIAN'S NAME (Type) E. Louis Kahan		Edgewood Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 4, 1959	
22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		22d. LOCATION (City, town, or county) (State) Bel Air, Harford, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard L. Williams		ADDRESS Abingdon, Maryland.	
24a. REC'D BY REGISTRAR FEB 5 '59		24b. REGISTRAR'S SIGNATURE Charles E. Kneass	

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David H. Johnson, Edward H. Johnson

E. Louis Kahn

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1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 26

500 1000 2000 3000 4000 5000 6000 7000 8000 9000 10000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1938

CERTIFICATE OF DEATH

01933

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen				c. LENGTH OF STAY IN 1b 17 Min			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US ARMY HOSPITAL ABERDEEN PROVING GROUND, MARYLAND				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FREELAND Middle JONES Last JONES				4. DATE OF DEATH Month February Day 14 Year 19 59			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 14 Feb 59	
9. AGE (In years last birthday) yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Carroll Freeland Jones				14. MOTHER'S MAIDEN NAME Gloria Hannon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Father			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity (Previabie Infant) 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 17 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1:03PM 14 Feb, 59 to 1:20PM 14 Feb, 59 , that I last saw the deceased alive on 1:20PM 14 Feb, 19 59 , and that death occurred at 1:20P M , from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles H P Westfall M.D.				ADDRESS (Street, city or town, state)		DATE SIGNED 14 Feb 59	
PHYSICIAN'S NAME (Type) CHARLES H P WESTFALL MAJOR MC				US ARMY HOSPITAL Aberdeen PG Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-18-59		22c. NAME OF CEMETERY OR CREMATORY Post Cemetery		22d. LOCATION (City, town, or county) (State) A. P. P. Aberdeen Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles J. Bullock - Harb. de Harb. Md.				24a. REC'D BY REGISTRAR FEB 20 '59		24b. REGISTRAR'S SIGNATURE Arthur S. H. H.	

1939

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Aberdeen				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Aberdeen,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route #1, Box 72				d. STREET ADDRESS Route #1, Box 72			
3. NAME OF DECEASED (Type or print) CHARLES ALONZO KEITHLEY				4. DATE OF DEATH Month February Day 1 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 Sept. 1877		9. AGE (In years last birthday) 81 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter				10b. KIND OF BUSINESS OR INDUSTRY Painting		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME James Keithley			
14. MOTHER'S MAIDEN NAME Cathrine Cullum				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 218-14-2358				17. INFORMANT Mrs. CHas. Alonzo Keithley, Aberdeen, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 wk 6 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 1949 , 19 2-1- 19 59 , that I last saw the deceased alive on 1-31- 19 59 , and that death occurred at 7:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Peter P. Rodman				ADDRESS (Street, city or town, state) 8 Law Street			
DATE SIGNED							
PHYSICIAN'S NAME (Type) Peter P. Rodman				Aberdeen, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/4/1959		22c. NAME OF CEMETERY OR CREMATORY St. Paul Luthern		22d. LOCATION (City, town, or county) (State) R.D. Aberdeen, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John F. Tarring				ADDRESS Tarring Funeral Home		24. REGISTRAR'S SIGNATURE Arthur S. Kraus	
DATE FEB 5 '59							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1930

Page 100

Name of Deceased Taylor, William		Sex Male	
Age 35		Date of Birth May 15, 1895	
Place of Birth Maryland		Usual Residence Route 1, Box 15	
Cause of Death Cholera		Date of Death August 10, 1930	
Place of Death Home		Physician Dr. J. H. Smith	
Burial Place St. John's Church		Burial Date August 12, 1930	
Name of Undertaker John Smith		Signature of Registrar [Signature]	
Name of Medical Officer [Signature]		Name of Health Officer [Signature]	

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18
1940 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
Item 2 Film 6239 3-9-59 et

01935

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Pennsylvania</i> b. COUNTY <i>Mont. Co.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Conowingo</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Villanova</i> 75X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Asphuncine, Susquehanna River</i>		d. STREET ADDRESS <i>609 Spruce Lane</i>	
3. NAME OF DECEASED (Type or print) <i>Gerhart Klapper</i>		4. DATE OF DEATH <i>February 27 1959</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 1 1915</i> 42 yrs.
9. AGE (In years last birthday) <i>42</i>		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Engineer Philadelpia Electric Co</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Pa</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Walter Klapper</i>		14. MOTHER'S MAIDEN NAME <i>Lura Radtke</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>Mar 11 1941</i>		16. SOCIAL SECURITY NO. <i>Mr Patricia Klapper</i>	
17. INFORMANT <i>Mr Patricia Klapper</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Decerebration</i> 863X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Fracture both femora</i> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Helicopter hit power line</i>	
20c. TIME OF INJURY Month, Day, Year <i>6 Hour 2-27-59</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <i>Susquehanna River Conowingo Harford Md.</i>	
20f. (City or town) <i>Harford</i> (County) <i>Harford</i> (State) <i>Md.</i>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <i>Gerald C Palmer</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> B-2 Air, Md. DATE SIGNED <i>2-27-59</i>	
EXAMINER'S NAME (Type) <i>Gerald C Palmer</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Feb 28, 1959</i>		22b. DATE THEREOF <i>Feb 28, 1959</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>West Laurel Hill</i>		22d. LOCATION (City, town, or county) <i>Phila. Pa.</i> (State) <i>Pa.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>C. Wallace Steward</i>		ADDRESS <i>Ardenmore, Pa</i>	
24a. REC'D BY REGISTRAR <i>DATE MAR 5 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Carlton S. Kline</i>	

FOR STATE
HEAD-DEPT

1010 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

THE
JAMES
BROOK

DATE OF DEATH
PLACE OF DEATH

AGE
SEX

CAUSE OF DEATH
MANNER OF DEATH

DATE OF DEATH

IF DEATH OCCURRED IN THE HOME, SIGNATURE OF PHYSICIAN

IF DEATH OCCURRED IN THE HOME, SIGNATURE OF PHYSICIAN



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1941

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01936

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Street</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Ralph</u> First <u>O. Knight</u> Middle <u>Lost</u>		4. DATE OF DEATH <u>Feb</u> Month <u>17</u> Day <u>1959</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>July 4, 1896</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Wool Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Harford Co Md</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Wilson Knight</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Low</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>Robert Knight</u>	
17. INFORMANT <u>Harold W. Grace</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden Heart Attack</u> <u>434.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac Arrest</u> DUE TO (c) <u>1 yr</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 15, 1959</u> to <u>Feb 17, 1959</u> , that I last saw the deceased alive on <u>Feb 15, 1959</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. P. Snodgrass</u>		DATE SIGNED <u>Warrington Md - 2/18/59</u>	
PHYSICIAN'S NAME (Type) <u>H. P. Snodgrass</u>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Feb 17, 1959</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Cn</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Baile</u>		ADDRESS <u>Warrington Md</u>	
24a. REC'D BY REGISTRAR DATE <u>FEB 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hays</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD

209

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01957

1923 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air				c. LENGTH OF STAY IN 1b 35 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Conv. Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ella Middle N. Last McCrobie				4. DATE OF DEATH Month February Day 8 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 7, 1880	
9. AGE (In years last birthday) 78 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY House work		11. BIRTHPLACE (State or foreign-country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Johnson Duncan			
14. MOTHER'S MAIDEN NAME Ruth Peters				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. None				17. INFORMANT Mrs. Lillian Trusler, Rt. # 3, Bel Air, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chr Cardio-vascular disease DUE TO (c) With hypertension						INTERVAL BETWEEN ONSET AND DEATH 2 hrs ? 12 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hemiplegic (nt-sided) due to cerebral vase disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from May 1950 19____, to Feb. 8 19____, that I last saw the deceased alive on Feb. 7 19____, and that death occurred at 1:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Willard P. Hudson, M.D.				ADDRESS (Street, city or town, state) Forest Hill md			
PHYSICIAN'S NAME (Type) Willard P. Hudson, M.D.				DATE SIGNED 2/9/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/11/59		22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		22d. LOCATION (City, town, or county) (State) Bel Air, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph J. Foster ADDRESS Bel Air, Md.				24a. REC'D BY REGISTRAR FEB 13 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Phares	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1942 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01938

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>69X-3</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hopkins Cove, Conowingo</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>✓</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hopkins Cove, Susquehanna River</u>			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Henry</u> Last <u>Meier</u>			4. DATE OF DEATH Month <u>February</u> Day <u>27</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jun 12, 1922</u>	9. AGE (in years last birthday) <u>36</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pilot Helicopter</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New York City</u>	
13. FATHER'S NAME <u>Wm H Meier</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Johnston</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes Par 2</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs Helen Meier</u> Address <u>103 Magazine</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushing Injury of chest with rupture of heart.</u> <u>863X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Compound, comminuted fracture of skull</u> DUE TO (c) <u>Third Degree Burns.</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Helicopter hit power line</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>6</u> <u>p. m.</u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Susquehanna River</u>	
				20f. (City or town) (County) (State) <u>Conowingo Harford Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>William V. Lovitt Jr.</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> Bel Air, Md. DATE SIGNED <u>2/28/59</u>	
EXAMINER'S NAME (Type) <u>William V. Lovitt Jr., M.D.</u>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 28, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New York City</u>	
				22d. LOCATION (City, town, or county) (State) <u>New York City</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u>		ADDRESS <u>Wilmington</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 3 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>William S. Kneass</u>	

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEATH RECORD

NAME OF DECEASED: John Doe
AGE: 45 SEX: Male
RACE: White COLOR: White
BIRTH DATE: 1910-01-15 BIRTH PLACE: New York City
RESIDENCE: 123 Main St, New York City

CAUSE OF DEATH

IMMEDIATE CAUSE: Myocardial Infarction
MANNER OF DEATH: Natural
UNDERLYING CAUSE: Coronary Atherosclerosis

DEATH RECORD

DATE OF DEATH: 1955-03-10 TIME OF DEATH: 10:00 AM
PLACE OF DEATH: Home
DECEASED'S SIGNATURE: John Doe
WITNESSES' SIGNATURES: John Doe, John Doe
MEDICAL EXAMINER'S SIGNATURE: John Doe
MEDICAL EXAMINER'S TITLE: Medical Examiner
MEDICAL EXAMINER'S ADDRESS: 123 Main St, New York City

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1943

CERTIFICATE OF DEATH

Reg. Dist. No.

01939

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rocks</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rocks</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Home</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>JAMES</i> Middle <i>P.</i> Last <i>MILLER</i>		4. DATE OF DEATH Month <i>FEB</i> Day <i>1</i> Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 12, 1913</i>
9. AGE (In years last birthday) <i>45</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Physician</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Physician, Md.</i>	
11. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Henry Condon Lay Miller</i>		14. MOTHER'S MAIDEN NAME <i>Elsie Groof</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mr. W. D. Pinkard - First National Bank Bldg</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CORONARY Occlusion</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Feb</i> , 1957, to <i>Feb 1</i> , 1959, that I last saw the deceased alive on <i>20 JAN</i> , 1959, and that death occurred at <i>1 P</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Thos. A. E. Moseley, Jr.</i>		M.D. <i>Warettsville, Md.</i>	
PHYSICIAN'S NAME (Type) <i>Thos. A. E. Moseley, Jr. M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>Feb. 3, 1959</i>	<i>St James Cemetery</i>	<i>My Lady's Manor. Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry W. Jenkins & Son, Co.</i>		ADDRESS <i>4905 YORK, Rd.</i>	
24a. REC'D BY REGISTRAR <i>FEB 4 59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur E. Thomas</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Race		5. Date of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Signature of informant	
John Doe		Male		45		White		Jan 1, 1900		Jan 15, 1945		New York City		Heart Disease		Natural		Dr. J. Smith		J. Doe		J. Doe	
13. Name of informant		14. Address of informant		15. Telephone number		16. Name of physician		17. Address of physician		18. Name of registrar		19. Address of registrar		20. Name of informant		21. Address of informant		22. Telephone number		23. Name of physician		24. Address of physician	
John Doe		123 Main St		1234		Dr. J. Smith		456 Elm St		J. Doe		789 Broadway		John Doe		123 Main St		1234		Dr. J. Smith		456 Elm St	



1944

CERTIFICATE OF DEATH

01940

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>RURAL BELAIR</u>		LENGTH OF STAY (in this place) <u>7 Mos.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>RURAL Pylesville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HARFORD CONVALESCENT HOME</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Bessie F. Neal</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>2-9-1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>OCT. 25, 1884</u>	9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>YORK CO., PENNA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>TOM WRIGHT</u>				14. MOTHER'S MAIDEN NAME <u>LAURA TAYLOR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Samuel Neal Pylesville, Md</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>						30 min.	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 4, 1958</u> , to <u>Feb. 9, 1959</u> , that I last saw the deceased alive on <u>Feb. 8, 1959</u> , and that death occurred at <u>12:45 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Willard P. Hudson</u>				M.D. <u>Forest Hill, Md.</u>		DATE SIGNED <u>2-9-59</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2-12-59</u>		NAME OF CEMETERY OR CREMATORY <u>SALEM METH. CEM.</u>		LOCATION (City, town, or county) (State) <u>DELTA, YORK CO., PA.</u>	
24. REC'D BY REGISTRAR DATE <u>FEB 16 '59</u>		REGISTRAR'S SIGNATURE <u>Travis S. House</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth W. Graham, Stewartstown, Pa.</u>		ADDRESS	

INSTRUCTIONS

1 hours after death.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

See Cert. No.

DATE OF DEATH

DECEASED

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

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2000-10-01

2000-10-01

CERTIFICATE OF DEATH

1941

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVERDE GRACE		c. LENGTH OF STAY IN 1b 45 hrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) STREET	
3. NAME OF DECEASED (Type or print) Annie Elizabeth Newcomb		4. DATE OF DEATH FEBRUARY 21 1959	
5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 2, 1890
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) BALTO., MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDWARD COOPER		14. MOTHER'S MAIDEN NAME MARY DENNIS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —	
17. INFORMANT MRS. WM. PATRICK, DARLINGTON, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Block - Chronic Myocarditis 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Vascular Renal Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2/17 , 19 59 , to 2-28 19 59 that I last saw the deceased alive on 2/20 19 59 , and that death occurred at 7:50 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE [Signature] M.D.		ADDRESS (Street, city or town, state) 3/28/59 DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2-23-59	22c. NAME OF CEMETERY OR CREMATORY HOLY CROSS	22d. LOCATION (City, town, or county) (State) STREET, HARFORD Co. MD.
23. FUNERAL DIRECTOR'S SIGNATURE John H. Harkins, Delta, Pa. ADDRESS		24a. REC'D BY REGISTRAR DATE FEB 26 '59	24b. REGISTRAR'S SIGNATURE [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1925 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01942

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. LENGTH OF STAY IN TB <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Paris-Lington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>				f. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Patricia S. Percy</u>				4. DATE OF DEATH Month <u>February</u> Day <u>9</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-16-38</u>		9. AGE (In years last birthday) <u>20</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Francis S. Silver</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Elliott</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Sara E Silver</u> Address <u>Paris-Lington, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral contusion</u> <u>816X</u> DUE TO (b) <u>Q.L. Pneumothorax</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>-</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident, auto - auto type</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>2-5</u> 19 <u>59</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Deer Creek Bridge</u>		20f. (City or town) (County) (State) <u>MSI. Street Harford Md.</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gerald C Palmer</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md</u> DATE SIGNED <u>2-10-59</u>			
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Feb 11, 1959</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Parlington Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Harford Co, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H S Bailey</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

MEDICAL CERTIFICATION

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1945 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01943

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DEL AIR</u>	c. LENGTH OF STAY IN 1b <u>30 YRS</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEL AIR (RURAL)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>RURAL RD #2 BOX 52 SHUCKS RD</u>		d. STREET ADDRESS <u>SCHUCKS RD</u>	
3. NAME OF DECEASED (Type or print) First <u>LUTHER</u> Middle <u>ESTEL</u> Last <u>QUILLEN</u>		4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>21</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 20, 1881</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>MARLON QUILLEN</u>	
14. MOTHER'S MAIDEN NAME <u>ELISABETH WALTON</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>220-24-1301</u>		17. INFORMANT <u>(WIFE) EUHA</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO SCLEROTIC (CARDIO VASCULAR) DISEASE</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>30 MIN</u> <u>?</u> <u>OVER 3 YRS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour _____ a. m. _____ p. m. _____ 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Notural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Philip W. Heuman</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>PHILIP W. HEUMAN</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>February 21, 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>Feb 24/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT Zion</u>	22d. LOCATION (City, town, or county) (State) <u>Fountain Green Harford - Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Foster Belcher</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 26 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1946

CERTIFICATE OF DEATH

Reg. Dist. No.

01944

1. PLACE OF DEATH o. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ABERDEEN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ABERDEEN	
c. LENGTH OF STAY IN 1b 7 DAYS		d. STREET ADDRESS 103-G RODMAN ROAD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US ARMY HOSPITAL, APG, MD.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CLEM (none) REID		4. DATE OF DEATH Month Day Year FEBRUARY 28 1959	
5. SEX MALE	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 23, 1869
9. AGE (In years last birthday) yrs. 89		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Farmer	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Reid		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT James E. Pittman, 103G Rodman Road, Aberdeen, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 7 Days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from February 21, 1959 , to February 28, 1959 , that I last saw the deceased alive on February 27, 1959 , and that death occurred at 3:05 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED US Army Hospital February 28, 59			
ACTUAL SIGNATURE Thomas J. Fraher M.D. US Army Hospital February 28, 59			
PHYSICIAN'S NAME (Type) THOMAS J. FRAHER, Captain, MC Aberdeen Proving Ground, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 3/2/59	22c. NAME OF CEMETERY OR CREMATORY Mt. Hope Baptist	22d. LOCATION (City, town, or county) (State) Jacksonville, Alabama
23. FUNERAL DIRECTOR'S SIGNATURE Elmer E. Bullock		ADDRESS Have de Grace, Md	
24a. REC'D BY REGISTRAR DATE MAR 4 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1913

NAME

RESIDENCE

AGE

SEX

7

DATE OF DEATH

TIME

PLACE OF DEATH

CAUSE OF DEATH

DATE

DECEASED

SEX

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18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01945

1947

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Whiteford</u>				c. LENGTH OF STAY IN 1b <u>73 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNA WHITEFORD SILVER</u>				4. DATE OF DEATH Month Day Year <u>February 17, 19 59</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 20, 1874</u>	9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance Agent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>		11. BIRTHPLACE (State or foreign country) <u>Flintville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James H. Whiteford</u>				14. MOTHER'S MAIDEN NAME <u>Mary L. Gladden</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>David Silver, Whiteford, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension C-V Disease</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>12/26/58</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1940</u> , to <u>Feb 17, 19 59</u> , that I last saw the deceased alive on <u>Feb 16, 19 59</u> , and that death occurred at <u>2:30</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph A. Hunt</u> M.D.				ADDRESS (Street, city or town, state) <u>Delta, Pa.</u>		DATE SIGNED <u>2/19/59</u>	
PHYSICIAN'S NAME (Type) <u>Hosiah A. Hunt M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 20, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Slateville</u>		22d. LOCATION (City, town, or county) (State) <u>Delta, York Co., Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Harkins</u>				ADDRESS <u>Delta, Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 20 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1984

1. Name of deceased		2. Sex		3. Date of birth		4. Date of death	
5. Place of birth		6. Usual residence		7. Cause of death		8. Manner of death	
9. Signature of physician		10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of funeral director		14. Signature of coroner		15. Signature of medical examiner		16. Signature of pathologist	
17. Signature of coroner's jury		18. Signature of jury		19. Signature of jury		20. Signature of jury	
21. Signature of jury		22. Signature of jury		23. Signature of jury		24. Signature of jury	
25. Signature of jury		26. Signature of jury		27. Signature of jury		28. Signature of jury	
29. Signature of jury		30. Signature of jury		31. Signature of jury		32. Signature of jury	
33. Signature of jury		34. Signature of jury		35. Signature of jury		36. Signature of jury	
37. Signature of jury		38. Signature of jury		39. Signature of jury		40. Signature of jury	
41. Signature of jury		42. Signature of jury		43. Signature of jury		44. Signature of jury	
45. Signature of jury		46. Signature of jury		47. Signature of jury		48. Signature of jury	
49. Signature of jury		50. Signature of jury		51. Signature of jury		52. Signature of jury	
53. Signature of jury		54. Signature of jury		55. Signature of jury		56. Signature of jury	
57. Signature of jury		58. Signature of jury		59. Signature of jury		60. Signature of jury	
61. Signature of jury		62. Signature of jury		63. Signature of jury		64. Signature of jury	
65. Signature of jury		66. Signature of jury		67. Signature of jury		68. Signature of jury	
69. Signature of jury		70. Signature of jury		71. Signature of jury		72. Signature of jury	
73. Signature of jury		74. Signature of jury		75. Signature of jury		76. Signature of jury	
77. Signature of jury		78. Signature of jury		79. Signature of jury		80. Signature of jury	
81. Signature of jury		82. Signature of jury		83. Signature of jury		84. Signature of jury	
85. Signature of jury		86. Signature of jury		87. Signature of jury		88. Signature of jury	
89. Signature of jury		90. Signature of jury		91. Signature of jury		92. Signature of jury	
93. Signature of jury		94. Signature of jury		95. Signature of jury		96. Signature of jury	
97. Signature of jury		98. Signature of jury		99. Signature of jury		100. Signature of jury	

1. This certificate is to be filled out by the physician or coroner who has examined the body of the deceased.

2. The cause of death should be stated in as much detail as possible, and should be based on the findings of the physician or coroner.

3. The manner of death should be stated as natural, accidental, suicidal, homicidal, or undetermined.

4. The signature of the physician or coroner must be in ink, and must be accompanied by the official seal of the office.

5. The signature of the registrar must be in ink, and must be accompanied by the official seal of the office.

6. The signature of the informant must be in ink, and must be accompanied by the official seal of the office.

7. The signature of the witness must be in ink, and must be accompanied by the official seal of the office.

8. The signature of the funeral director must be in ink, and must be accompanied by the official seal of the office.

9. The signature of the coroner must be in ink, and must be accompanied by the official seal of the office.

10. The signature of the medical examiner must be in ink, and must be accompanied by the official seal of the office.

11. The signature of the pathologist must be in ink, and must be accompanied by the official seal of the office.

12. The signature of the coroner's jury must be in ink, and must be accompanied by the official seal of the office.

13. The signature of the jury must be in ink, and must be accompanied by the official seal of the office.

14. The signature of the jury must be in ink, and must be accompanied by the official seal of the office.

15. The signature of the jury must be in ink, and must be accompanied by the official seal of the office.

16. The signature of the jury must be in ink, and must be accompanied by the official seal of the office.

17. The signature of the jury must be in ink, and must be accompanied by the official seal of the office.

18. The signature of the jury must be in ink, and must be accompanied by the official seal of the office.

19. The signature of the jury must be in ink, and must be accompanied by the official seal of the office.

20. The signature of the jury must be in ink, and must be accompanied by the official seal of the office.

1926

CERTIFICATE OF DEATH

Reg. Dist. No.

01946

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 Harre-de-Grace</u>	
c. LENGTH OF STAY in 1b <u>3 days</u>		d. STREET ADDRESS <u>1417 Lewis ST.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Baby Boy SIMONS</u>		4. DATE OF DEATH Month <u>2</u> Day <u>26</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/23/59</u>
9. AGE (In years lost birthday) <u>—</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>3</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>MD.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Jay S. Simons</u>	
14. MOTHER'S MAIDEN NAME <u>Nancy Easter</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Jay S. Simons 417 Lewis ST. City.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia (with 2 lbe)</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>(5-6 month gestation)</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>—</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>2/23, 1959</u> , to <u>2/26, 1959</u> , that I last saw the deceased alive on <u>2/26, 1959</u> , and that death occurred at <u>10 P.</u> M, from the causes and on the date stated above.	
ADDRESS (Street, city or town, state) <u>Harre-de-Grace MD</u>		DATE SIGNED <u>2/27/59</u>	
ACTUAL SIGNATURE <u>Frank Wolbert MD</u>		PHYSICIAN'S NAME (Type) <u>FRANK WOLBERT MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-28-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FARM GARDEN HOUSE</u>		22d. LOCATION (City, town, or county) (State) <u>HARFORD CO. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>N. Madison Mitchell</u> ADDRESS <u>HARRE DE GRACE MD</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 2 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

2000385XVO

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 1948 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01947

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <i>Harpord</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Harpord</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Havre de Grace</i>		c. LENGTH OF STAY IN 1b <i>LIFE</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>700 S Washington St</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Aervey Dugan Skipper</i>		4. DATE OF DEATH <i>February 3 1959</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 31, 1888</i>
9. AGE (In years last birthday) <i>70</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Alexander Dugan</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Cross</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Albert Dugan Skipper</i>		Address <i>HAVRE DE GRACE MD</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic CV disease</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Gerald C Palmer</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> Bel Air, Md. DATE SIGNED <i>2-3-59</i>	
EXAMINER'S NAME (Type) <i>Gerald C Palmer MD</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>FEB. 5, 1959</i>	22c. NAME OF CEMETERY OR CREMATORY <i>ANGEL HILL CEM</i>	22d. LOCATION (City, town, or county) (State) <i>HAVRE DE GRACE MD</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. Madison Mitchell</i>		ADDRESS <i>Havre de Grace MD.</i>	
24a. REC'D BY REGISTRAR <i>Feb 5 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Howard</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1927

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01948

Reg. Dist. No.

FOR STATE
HEALTH DEPT.1. PLACE OF DEATH
a. COUNTY

Harford

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

b. COUNTY

Md Harford

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Aberdeen

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

31 Aberdeen

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Ryans Trailer Camp

d. STREET ADDRESS

131 W. Phila. Blvd.

e. IS RESIDENCE
ON A FARM?
YES ☐ NO ☒3. NAME OF
DECEASED
(Type or print)

Donald First Engine S Tyer Last

4. DATE
OF
DEATH

February

Month Day Year

8 1959

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

Dec 8, 1958

9. AGE (In years
last birthday)

yrs. 2

10. UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Infant

10b. KIND OF BUSINESS OR INDUSTRY

Infant

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles L. Tyer

14. MOTHER'S MAIDEN NAME

Florence Adams

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Father: 131 W. Phila Blvd Aberdeen Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

491X

DUE TO

Bronchopneumonia

Conditions, if any, which
gave rise to immediate cause

(b)

(a), stating the underlying
cause last.

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

INTERVAL BETWEEN
ONSET AND DEATH19. WAS AUTOPSY
PERFORMED?
YES ☐ NO ☒20a. EXTERNAL CAUSE WAS
PRIMARY ☐ or CONTRIBUTING ☐
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour a. m.
p. m.

19

20d. INJURY OCCURRED

While at work ☐ Not while at work ☐20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐. Inspection ☒. Inquiry ☐. and in my opinion death resulted from: Natural causes ☒. Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☐ACTUAL
SIGNATURE

Gerald E Palmer

M.D.

CHIEF MEDICAL EXAMINER ☐

Bel Air Md

DATE SIGNED

EXAMINER'S
NAME (Type)

Gerald E Palmer M.D.

ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

2-10-59

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial 2/10/59

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

Bakers Cemetery

22d. LOCATION (City, town, or county)

Aberdeen Maryland

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

John F. Barry Aberdeen Maryland

ADDRESS

24a. REC'D BY REGISTRAR

FEB 11 '59

24b. REGISTRAR'S SIGNATURE

Arthur S. Kline

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

207/244xv5

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **72 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1949 CERTIFICATE OF DEATH

01949

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u> MARYLAND		STATE <u>Maryland</u> COUNTY <u>Harford</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Bel Air</u> Rural		LENGTH OF STAY (in this place) <u>3 Mons.</u>		TOWN <u>Jarrettsville</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Convalescing Home</u>				STREET ADDRESS			
3. NAME OF DECEASED (First) (Middle) (Last) <u>BESSIE</u> <u>MAY</u> <u>TRACEY</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>February 1,</u> <u>19 59</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>July 16, 1887</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical Nurse Nursing</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>		11. BIRTHPLACE (State or foreign country) <u>Rocks Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Thomas Ervin</u>				14. MOTHER'S MAIDEN NAME <u>Martha Crew</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-34-5638A</u>		17. INFORMANT & ADDRESS <u>Mrs Helen Crouse Aberdeen Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
4221 IMMEDIATE CAUSE (A) <u>Bronchopneumonia, terminal</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Cerebral thrombosis, acute, severe</u>						<u>1 week</u>	
DUE TO (C) <u>arteriosclerotic cardiovascular disease</u>						<u>10 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>carcinoma of cervix (treated 4 months ago; arrested)</u>						<u>1 year</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 5</u> , 19 <u>59</u> , to <u>Feb. 1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb. 1</u> , 19 <u>59</u> , and that death occurred at <u>4:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Paul S. Stoner, Jr.</u>				ADDRESS (Street, city, town, state) <u>M.D. 115 Fulford Ave., Bel Air, Md.</u>			
DATE SIGNED <u>2/2/59</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/5/1959</u>		NAME OF CEMETERY OR CREMATORY <u>North Bend</u>		LOCATION (City, town, or county) (State) <u>Rocks RD Md.</u>	
24. REC'D BY REGISTRAR <u>FEB 4 '59</u>		REGISTRAR'S SIGNATURE <u>Arthur S. Stoner</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles C. Kurtz Jarrettsville Md.</u>			

1923 CERTIFICATE OF DEATH

Reg. Dist. No.

1. Name of deceased

2. Sex
3. Age
4. Date of birth
5. Place of birth

6. Race
7. Religion

8. Occupation
9. Usual place of abode

10. Name of physician

11. Date of death

12. Cause of death

13. Manner of death

14. Place of death

15. Name of informant

16. Name of physician

17. Date of death

18. Name of physician

19. Date of death

20. Name of physician

21. Date of death

22. Name of physician

23. Date of death

24. Name of physician

25. Date of death

26. Name of physician

27. Date of death

28. Name of physician

29. Date of death

30. Name of physician

31. Date of death

32. Name of physician

33. Date of death

34. Name of physician

35. Date of death

36. Name of physician

37. Date of death

38. Name of physician

39. Date of death

40. Name of physician

41. Date of death

42. Name of physician

43. Date of death

DEPARTMENT OF HEALTH

1. Name of deceased
2. Sex
3. Age
4. Date of birth
5. Place of birth
6. Race
7. Religion
8. Occupation
9. Usual place of abode
10. Name of physician
11. Date of death
12. Cause of death
13. Manner of death
14. Place of death
15. Name of informant
16. Name of physician
17. Date of death
18. Name of physician
19. Date of death
20. Name of physician
21. Date of death
22. Name of physician
23. Date of death
24. Name of physician
25. Date of death
26. Name of physician
27. Date of death
28. Name of physician
29. Date of death
30. Name of physician
31. Date of death
32. Name of physician
33. Date of death
34. Name of physician
35. Date of death
36. Name of physician
37. Date of death
38. Name of physician
39. Date of death
40. Name of physician
41. Date of death
42. Name of physician
43. Date of death

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 1950 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01950

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

1. PLACE OF DEATH a. COUNTY <u>Harford</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Conowingo</u> c. LENGTH OF STAY IN 1b <u>2</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hypkins Cove, Susquehanna River</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darlington</u> d. STREET ADDRESS <u></u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert E. Turner</u>	4. DATE OF DEATH <u>February 27</u> 19 <u>59</u>	5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>MAR. 23, 1901</u> 9. AGE (In years and days) <u>57</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PLANT ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HYDRO-ELECTRIC</u>	
11. BIRTHPLACE (State or foreign country) <u>ODEBOLT, IOWA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE TURNER</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA HENDERSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>174-10-733</u>	
17. INFORMANT <u>REBECCA TURNER, CONOWINGO, MD.</u>		Address <u></u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull</u> 863X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture L femur</u> DUE TO (c) <u>Third Degree Burns Body</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Helicopter hit power line</u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Helicopter hit power line</u>	
20c. TIME OF INJURY Month, Day, Year <u>2-27-59</u> Hour <u>6</u> a.m. <u>6</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Susquehanna River Conowingo</u> (City or town) <u>Harford</u> (County) <u>Md.</u> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <u>Bel Air Md</u> DATE SIGNED <u>2-27-59</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAR 2, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>DARLINGTON</u>		22d. LOCATION (City, town, or county) <u>DARLINGTON, MD.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Harkins, Delta, Pa.</u>		24a. REC'D BY REGISTRAR <u>MAR 3 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

MEDICAL CERTIFICATION

12

2

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: John A. Smith
2. Date of Death: 10-15-1910
3. Place of Death: Home
4. Age: 45 Years
5. Sex: Male
6. Race: White
7. Occupation: Engineer
8. Cause of Death: Heart Disease
9. Duration of Illness: Several Days
10. Name of Physician: Dr. J. B. Jones
11. Name of Medical Examiner: Dr. C. D. Brown
12. Signature of Medical Examiner: [Signature]
13. Date of Examination: 10-16-1910
14. Place of Examination: Home
15. Name of Coroner: Mr. W. H. Clark
16. Name of Jury: Mr. J. K. Lee, Mr. R. M. White, Mr. T. N. Green
17. Name of Witnesses: Mr. A. B. Black, Mr. C. D. Brown
18. Name of Undertaker: Mr. F. G. Hall
19. Name of Burial Place: St. John's Cemetery
20. Name of Minister of Religion: Rev. J. L. King
21. Name of Funeral Home: None
22. Name of Embalmer: None
23. Name of Crematorium: None
24. Name of Interment: None
25. Name of Disposition: None
26. Name of Other: None

FOR STATE
NEW YORK
1910
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1928

CERTIFICATE OF DEATH

01951

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen c. LENGTH OF STAY IN 1b 2 Years d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 319 Graceford Drive				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 Aberdeen d. STREET ADDRESS 319 Graceford Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) LEO FRANCIS VANCE		4. DATE OF DEATH Month February Day 6 Year 1959		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 22, 1918		9. AGE (In years last birthday) 40		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Army Officer				10b. KIND OF BUSINESS OR INDUSTRY US Army				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME William Francis Vance						14. MOTHER'S MAIDEN NAME Unknown											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes WWII, Korean				16. SOCIAL SECURITY NO. 214-07-4060				17. INFORMANT Official Military Records				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe Coronary Arteriosclerosis and fatty liver. DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH																	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)																	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from Feb 6, 1959 to Feb 6, 1959 , that I last saw the deceased alive on Feb 6, 1959 , and that death occurred at Approx. 3:15 P M, from the causes and on the date stated above.																	
ADDRESS (Street, city or town, state) US Army Hospital DATE SIGNED Feb 6, 1959																	
ACTUAL SIGNATURE Jerome B. Bryant Jr. Major, MC																	
PHYSICIAN'S NAME (Type) JEROME B. BRYANT Jr., Major, MC																	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 2-10-59				22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.				22d. LOCATION (City, town, or county) (State) Arlington, Va.					
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook - Blight Inc. 6009 Harford Rd. Balto 14, Md.																	
24a. REC'D BY REGISTRAR FEB 13 '59																	
24b. REGISTRAR'S SIGNATURE Arthur L. Howard																	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

220

1925

CERTIFICATE OF DEATH

Reg. Dist. No.

01952

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>25 HRS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSP.</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Baby Boy WALLS</u>		4. DATE OF DEATH <u>FEBRUARY 2</u> 19 <u>59</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-1-59</u>
9. AGE (In years lost birthday) yrs. <u>24</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>24 54</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <u>MARION WALLS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HELECTASIS</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>PREMATURITY</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>12 Hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2/1, 1959</u> , to <u>2/2, 1959</u> , that I last saw the deceased alive on <u>2/2, 1959</u> , and that death occurred at <u>6:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. P. Ross</u>		ADDRESS (Street, city or town, state) <u>200 A 7th Union Ave.</u>	
PHYSICIAN'S NAME (Type) <u>J. P. Ross</u>		DATE SIGNED <u>Harve de Grace, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>2-2-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HARFORD MEMORIAL HOSPITAL</u>	22d. LOCATION (City, town, or county) (State) <u>Harve de Grace Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hungarway Administrator</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 6 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1930

CERTIFICATE OF DEATH

Reg. Dist. No.

01953

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Ohio</i> b. COUNTY <i>Cuyahoga</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harve de Grace</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cleveland - 6 72 X-3</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harford Memorial Hospital</i>		d. STREET ADDRESS <i>2128 East 100th Street</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>HATTIE MILDRED WILLIAMS</i>		4. DATE OF DEATH Month Day Year <i>February 20 1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 28, 1912</i>
9. AGE (In years last birthday) <i>46 yrs.</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <i>5 8</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	
11. BIRTHPLACE (State or foreign country) <i>Cincinnati, Ohio</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Thomas Childs</i>		14. MOTHER'S MAIDEN NAME <i>Hattie Kelley</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>-</i>		16. SOCIAL SECURITY NO. <i>355-18-6884</i>	
17. INFORMANT <i>Mr. Joseph Williams</i>		Address <i>2128 E 100th Street Cleveland, Ohio</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>416X Congestive Heart Failure</i> DUE TO (b) <i>Chronic Rheumatic Heart disease</i> DUE TO (c) <i>Chronic Rheumatic Heart disease</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>2/15</i> , 19 <i>59</i> , to <i>2/20</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>2/20</i> , 19 <i>59</i> , and that death occurred at <i>4:10 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>George T. Stansbury</i>		ADDRESS (Street, city or town, state) <i>589 Revolution St. Harve de Grace, Md.</i>	
PHYSICIAN'S NAME (Type) <i>George T. Stansbury</i>		DATE SIGNED <i>2/20/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	22b. DATE THEREOF <i>2/21/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Highland Park Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Cleveland Ohio</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Elmer E. Bullock</i>		ADDRESS <i>Harve de Grace</i>	
24a. REC'D BY REGISTRAR <i>FEB 24 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1950

DEPARTMENT OF HEALTH
BALTIMORE, MD.

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of health officer		17. Signature of coroner		18. Signature of jury	
19. Signature of jury		20. Signature of jury		21. Signature of jury	
22. Signature of jury		23. Signature of jury		24. Signature of jury	
25. Signature of jury		26. Signature of jury		27. Signature of jury	
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94. Signature of jury		95. Signature of jury		96. Signature of jury	
97. Signature of jury		98. Signature of jury		99. Signature of jury	
100. Signature of jury		101. Signature of jury		102. Signature of jury	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01954

FOR STATE
HEALTH DEPT.

1951

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. LENGTH OF STAY IN 1b <u>x</u> <u>Churchville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RDI</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joan</u> First <u>Dell</u> Middle <u>Wilson</u> Last		4. DATE OF DEATH <u>February</u> Month <u>28</u> Day <u>19</u> Year <u>59</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>14 Sept. 1942</u>	
9. AGE (In years last birthday) <u>16</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Woodrow Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Ruby Mae Lynch</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>T.W. Wilson,</u> Address <u>Churchville, Maryland</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull</u> <u>816x</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Fracture L femur</u> (a), stating the underlying cause last. DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Auto accident auto type</u>	
20c. TIME OF INJURY Month, Day, Year <u>11-28-59</u> Hour <u>2-28</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Bel Air</u>		20f. (City or town) (County) (State) <u>Harford md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <u>Bel Air, md</u> DATE SIGNED <u>3-1-59</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>3/3/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Miller Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Webster Springs, W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Barring</u> ADDRESS <u>Aberdeen, Md.</u>		24a. REC'D BY REGISTRAR <u>MAR 4 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

